

Minimum Data Set (MDS) for Home Care

1

Score for Behavior/Function over past 7 days

Client Name _____ Date _____

Medical Assistance Number _____ Agency _____

Agency Provider Number(s) _____ RN Signature _____

Section B: Cognitive Patterns

1. Memory Short Term Memory appears OK-Seems to recall after 5 minutes ☐
0-Memory OK 1-Memory Problem
2. Cognitive Skills How well client made decisions about organizing the day (e.g. when
 For Daily Decision to get up or have meals, which clothes to wear) ☐
 Making *0 Independent-decisions consistently reasonable*
1 Modified Independence-some difficulty in new situations
2. Moderately Impaired-decisions poor, cues/supervision needed
3. Severely Impaired-never/rarely makes decisions
3. Indicators of Delirium a. Sudden or new onset/change in mental function (including ability
 to pay attention, awareness of surroundings, coherentness. ☐
0 No 1 Yes
- b. In the last 90 days client has become disoriented or agitated such that
 his/her safety is endangered or client requires protection by others. ☐
0 No 1 Yes

TOTAL COGNITIVE (B1, 2, and 3) _____

Section E: Mood and Behavior Patterns

1. Indicators of depression, anxiety, sad mood *Indicators observed in last 30 days regardless of cause*
0 Indicator not exhibited in last 30 days
1 Indicator exhibited up to 5 times each week
2. Indicator of this type exhibited daily (6 or more times weekly)
- a. A feeling of sadness or being depressed, that life
 Is not worth living, that nothing matters, that he/she
 is of no use to anyone or would rather be dead ☐
- b. Persistent anger with self or others-e.g. easily
 annoyed, anger at care received ☐
- c. Expressions of what seem to be unrealistic
 fears (of being abandoned, etc) ☐
- d. Repetitive health complaints-e.g.
 obsessive concern w/ body functions, health ☐
- e. Repetitive, anxious complaints/
 concerns-e.g. persistently seeks
 attention/reassurance regarding
 schedules, meals, relationships ☐
- f. Sad, pained, worried facial
 expressions-e.g. furrowed brow ☐
- g. Recurrent crying/tearfulness ☐
- h. Withdrawal from activities of
 interest ☐
- i. Reduced social interaction ☐

TOTAL MOOD (E 1, a-i) _____

Behavior Patterns

2. Behavioral Symptoms *Exhibited in the past seven days*
0 Did not occur in past seven days
1 Occurred, easily altered
2 Occurred, not easily altered
- a. Wandering (moved with no rational purpose) ☐
- c. Physically Abusive Behavior (to self or others) ☐
- e. Aggressive Resistance of Care (Threw meds,
 pushed caregiver, etc) ☐
- b. Verbally Abusive Behavior (threatened,
 or cursed at others) ☐
- d. Socially Inappropriate/Disruptive Behavior
 (smears, throws body feces, screams,
 disrobing in public) ☐
3. Changes in Behavior Behavioral symptoms have become worse over past 30 days ☐
0 No 1 Yes

TOTAL BEHAVIOR (E 2, 3) _____

Section H Physical Functioning

1. Activities of Daily Living (ADLs) (Consider all instances over past seven days)

0 Independent - No help or oversight, OR help/oversight provided only 1 or 2 times over past week

1 Supervision - Oversight or cueing provided 3 or more times, possible physical assistance less than three times

2 Limited Assistance - Client highly involved in activity, received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times

3 Extensive Assistance - Client participated, but weight bearing support OR full assistance given three or more times

4 Total Dependence - Full performance of activity by another over entire seven days

5 Activity did not occur over entire seven days regardless of ability

- | | | |
|-----------------------|--|--|
| a. Mobility in Bed | Moving to and from lying position, turning, and positioning body in bed | |
| b. Transfer | To and between surfaces-bed, chair, standing position (exclude bathroom transfers) | |
| c. Locomotion in Home | If in wheelchair, self-sufficiency once in chair | |
| d. Dressing | Includes laying out clothes, retrieving from closet, putting on and taking off | |
| e. Eating | Include taking in food by any method including tube-feeding | |
| f. Toileting | Include using toilet, commode, bedpan, urinal, catheter, transfers, cleaning self and managing clothing | |
| g. Personal Hygiene | Combing hair, brushing teeth, washing face and hands, shaving | |
| 2. Bathing | Include shower, sponge bath, tub bath | |
| 3. Locomotion | 0 No assistive device
1 Cane
2 Walker/Crutch
3 Scooter
4. Wheelchair
5. Activity does not occur | |
| a. Indoor Locomotion | | |
| b. Outdoor Locomotion | | |

TOTAL ADLS (H 1,2,3) _____

Instrumental Activities of Daily Living (IADLs)-Code for functioning in everyday activities in the home

IADL Self-Performance Code

Independent-did on own (I)

Some Help-Help some of the time (SH)

Full Help-Needs some help all the time (FH)

By Others-Always performed by others (BO)

Activity did not occur (NA)

PERFORMANCE

- | | | |
|-------------------------|---|--|
| a. Meal Preparation | Planning, cooking and set-up | |
| b. Ordinary Housework | Dusting, making bed, laundry, tidying | |
| c. Managing Finances | Pay bills, balance checkbook | |
| d. Managing Medications | Remembering, correct doses, ointments, injections
opening containers | |
| e. Phone Use | How made or received, finding numbers | |
| f. Shopping | Food, household goods | |
| g. Transportation | Medical and social events | |

(NO SCORE-FOR INFORMATIONAL PUPOSES ONLY)

FAX completed forms to: ATTENTION: EDS Prior Authorization Department at (401) 941-7712

Or Mail to: EDS

P O BOX 2006

Warwick, RI 02887-2006

ATTENTION: EDS PRIOR AUTHORIZATION DEPARTMENT

Appendix C

Client Acuity

Enhanced Reimbursement: \$1.00 per hour of Personal Care and Combination Personal Care and Homemaker Service provided to a client assessed as being high acuity by the agency Registered Nurse based on sections of the MDS for Home Care.

Qualifications: A client is considered high acuity if they receive a following minimum score by an agency Registered Nurse in one area:

- a. “5” on Section B, Items 1, 2, and 3, OR
- b. “16” on Section E, Item 1, OR
- c. “8” on Section E, Items 2 and 3, OR
- d. “36” on Section H, Items 1, 2, and 3

Or, if they receive the following minimum scores in two or more areas:

- a. “3” on Section B, Items 1, 2, and 3
- b. “8” on Section E, Item 1
- c. “4” on Section E, Items 2 and 3
- d. “18” on Section H, Items 1,2, and 3

The agency must collect and submit this data on all Medical Assistance clients in order to receive the enhancement for those with high acuity.

How to Receive Enhancement: Submit the adapted MDS (enclosed) on clients meeting the above minimum criteria directly to EDS for a six month authorization as soon as it is completed. All MDS forms must be signed by an R.N., dated, and totaled for each section. The remaining MDS forms on Medical Assistance clients (not assessed as high acuity) should be mailed to the DHS Center for Adult Health every six months, the first set due six months from return of the General Application for enhanced reimbursements.

Claims submitted for clients meeting the acuity standard should be billed at the correct amount with the modifier xxxx. Note: some claims may have two modifiers if the client meets the high acuity determination and the service is provided evenings, nights, weekends or holidays.

Necessary Forms: The adapted MDS for Home Care is required on all Medical Assistance clients in order for the enhanced reimbursement to be made on services for those of high acuity.

Monitoring Methods: EDS will enter client information on those meeting minimum acuity standards in their claims system to allow the enhanced payment to be made only on the appropriate claims, then will forward the MDS back to the DHS Center for Adult Health. All MDS data will be reviewed by DHS clinical staff, and spot checks will be conducted between DEA collected MDS data, client assessment by DHS staff and submitted MDS data from the agency.